Healthpoint

Information from the Division of Health Care Finance and Policy

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WHAT'S DRIVING PRESCRIPTION DRUG COSTS?

Prescription drugs and their associated costs are currently receiving a lot of attention from health care organizations, policy makers and consumers. While inflation, including medical inflation, has been at its lowest in twenty years, prescription drugs have been primarily responsible for recent increases (sometimes steep) in insurance premiums and patient out of pocket expenses. According to IMS Health, Inc., a national company that tracks prescription data, prescription sales are expected to produce a compounded average growth rate of 9.8% over the 1998-2002 period. This edition of *Healthpoint* examines *why* prescription drugs are responsible for a larger share of the health care budget and discusses the impact of drug utilization on the provision of cost-effective, quality health care in Massachusetts.

The Fastest Growing Component of Health Care Costs

The prescription drug category is currently the fastest growing component of the health care budget. While until recently prescription drugs represented only a small fraction of the health care budget, today they represent up to 15% of total health expenditures for certain insurers, with some reporting prescription drug budgets that exceed the annual amount spent on doctors.[1] Drug costs, if unchecked, could exceed hospital costs (typically the most expensive component of health care) in a few years. The rapid increase in spending for prescription drugs is one reason employers expect premiums to rise anywhere from 4% to 15% in 1999, after years of no or low single-digit increases.[2] In Massachusetts, the Medicaid program has seen drug spending rise from 9% of its total expenditures in 1995 to a projected 15% in 1999.

A number of reasons are cited for the increased spending on prescription drugs. Among these are: 1) recent advances in research resulting in new and more expensive drugs to treat a multitude of diseases; 2) an aging population that will double to over 70 million people over age 65 by the year 2030; and 3) increasing consumer demand for prescriptions, driven by their health needs, direct consumer advertising, and in some cases, increased third party coverage.[3]

More New Drugs

For the most part, drugs currently on the market have played a limited role in the growth of prescription drug expenses. Rather, that growth is based on expensive new

brand name drugs that have recently entered the market and the demand that they create. In addition, the volume of prescriptions dispensed by pharmacies has been increasing an average of 5% per year over the past several years, reaching 2.4 billion prescriptions dispensed in 1997.[4] In Massachusetts, data provided by 11 Massachusetts HMOs, indicate that the overall number of prescriptions filled in 1997 compared to 1996 increased 6.8% for their fully insured commercial population.

When brand name drugs enter the market, they enjoy a period of patent protection for up to 20 years that is intended to assist drug manufacturers in recouping their research and development costs. The price of a drug is determined by a number of factors: the perceived value of the drug in terms of improving quality of life or health outcomes, whether the drug is a substitute for either a comparable drug or a surgical procedure, and its research and development costs. Historically, most new drugs entered the market at less than $2 a pill, but now a number of new products go for much more. Rezulin, a treatment for diabetes is about $4 a pill while Viagra, the impotence drug is $7-10 dollars a pill. The new cox-2 inhibitors for arthritis treatment will replace drugs costing about 20 cents with ones averaging $2.50. New biotechnology products, such as erythopotein for the treatment of anemia in patients with kidney disease, may cost up to $7,000 dollars or more a year.

Brand Name versus Generic Drugs

Brand name drugs comprise about 50% of all prescriptions filled, but they account for 80% of pharmaceutical spending.[5] Because most new drugs have no generic equivalent, there is no substitute for their use. In Massachusetts, state law requires pharmacists to substitute a generic drug (if available) for a brand name drug unless a physician writes “no substitution”. The state is considered to have a high generic substitution rate—the majority of prescriptions are filled with a generic equivalent, if available. Nevertheless, data from the fully insured commercial members of the eleven Massachusetts HMOs referenced above show that in 1997 there were 15% more brand name prescriptions filled than generics. With a presumably well managed drug benefit in place, this is most likely due to the lack of generic equivalents.

International Drug Pricing

United States firms lead the world in drug development, producing almost half of the new drugs introduced around the world between 1974 and 1994 . Drug makers cite the high cost of putting a drug through clinical trials (up to $150 million dollars or more a drug), with only a small fraction ever making it to market as one of the key reasons that brand name drugs are considerably more expensive than generics. However, brand name drugs typically see gross profits of over 90%, with net profits for the industry at about 18%.[6] Furthermore, prices for the same drug products in other countries such as Canada are typically 40% less than in the U.S. Most other countries, including Canada, have price controls limiting how much will be paid for drug products. Deep opposition by the pharmaceutical industry to this approach has made this politically infeasible in the U.S.

Advertising Appeal

New direct-to-consumer advertising campaigns that influence consumer demand for new drug products is seen as at least partially responsible for the recent dramatic increase in drug expenditures, especially among brand name drugs. In 1997, the FDA lifted restrictions on how manufacturers can advertise prescription drugs. In 1998, drug manufacturers spent over $1.3 billion in direct-

to- consumer advertising, a 50% increase from 1997.[7] One of the most widely prescribed medications, Claritan, a non-sedating antihistamine, is also one of the most heavily advertised products to consumers. Overall, according to IMS health, pharmaceutical manufacturers will spend about $11 billion this year on marketing compared to approximately $24 billion on research and development.[8,9]

Third Party Reimbursement

While it means more individuals have access to life saving therapies, insurance coverage is seen as a big contributor to the increased use of prescription drug therapies. Managed care has been quick to adopt drug therapy as an approach to prevent hospitalization and reduce long term costs of care, raising the question of whether insurers have at least partially offset the increased cost of drugs by savings in hospitalizations. And while third party payers have taken a larger role in managing and controlling reimbursement for prescription drugs, many Americans are either not insured at all, have a hospitalization policy with no drug coverage, or are covered under Medicare which does not include drug coverage. Rapidly increasing costs to insurers contribute to demands for increased cost sharing by patients and consideration of capping benefits. Recently, some Massachusetts managed care plans announced the implementation of increased (sometimes substantial) co-payments on certain brand name drugs if an alternative is available in the formulary. Even with insurance coverage, prescription drugs are the highest out of pocket expense category for individuals due to co-payment requirements.

Drug Problems for the Elderly

While the elderly make up only 12% of U.S. population, they use almost 35% of the prescription drugs dispensed. When Medicare was enacted in 1965, prescription drugs were a minor part of the treatment for most conditions, but today the primary treatment for these same conditions is likely to rely heavily on drug therapies. A recent Congressional commission to reform Medicare failed to reach consensus on a proposal to revamp the existing program with the sticking point being how (*not* whether) Medicare should provide prescription drug coverage. One concern is the very mixed support among seniors for raising premiums to pay for drug coverage since 65% of seniors already have drug coverage (see Figure 1). In 1988, when Congress passed a law to provide long-term care and prescription drug benefits through the Medicare program, many elderly reacted angrily to the increase in their Medicare premiums forcing Congress to repeal the law. Today, although drugs may reduce some costs of care, the addition of a drug benefit is projected to add at least $20 billion dollars to the existing Medicare program per year.

In 1998, Sixty-Five Percent of Medicare Beneficiaries Had Prescription Drug Coverage

Insurance Source

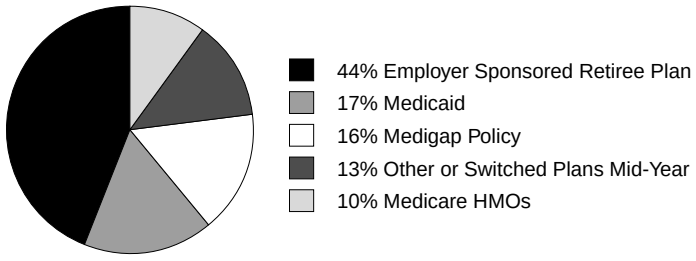

Figure 1

Source: National Bipartisan Commission on the Future of Medicare

The Search for Solutions

Policy makers face an array of issues in the debate over prescription drug coverage. It is anticipated that new drug development will continue to increase the demand for drug therapies and consume ever-larger portions of the health care budget. Issues of parity will also arise, as individuals whose only

source of treatment for a condition may be a drug therapy, may demand that they receive coverage comparable to those who undergo fully covered surgical or medical procedures for their conditions.

While waiting for a national solution to the problem, states have been hampered in their own efforts to solve the crisis by the federal preemption issue. In Massachusetts, federal preemption of Medicare laws allowed Medicare HMOs to restrict the level of coverage of prescription drugs for seniors wishing to purchase a Medicare HMO policy. While existing state pharmacy assistance programs target the most vulnerable, low-income individuals, even better off individuals are being strained by the cost to purchase needed medications. Currently, discussions in Massachusetts have focused on ensuring that all individuals have some coverage to protect against catastrophic prescription costs, expanding the existing Senior Pharmacy program or establishing a statewide purchasing program with rebates.

Another area of contention is the pricing of drugs. Without a national program such as Medicare purchasing drugs, individuals pay high retail prices for drugs due to cost shifting from discounts that third party payers negotiate. One reason there is strong pharmaceutical company opposition to the broadening of Medicare to include drug coverage is the fear that if the federal program covers drugs, they will negotiate discounts or price ceilings.

The issue over prescription drug coverage is similar to the broader issues surrounding access to health insurance coverage in general. While a majority is comfortable with their insurance and drug benefits coverage, the uninsured and underinsured minority is seeking ways to afford health insurance and benefits increasingly out of their reach.

Endnotes

1. Alex Pham, "Many to feel pinch of health-premium hike," *The Boston Globe* (11/19/98).
2. Ibid.
3. Elyse Tanouye, "U.S. has developed an expensive habit: now, how to pay for it?" *Wall Street Journal* (11/16/98).
4. IMS Health, Inc., "IMS Health Reports U.S. Health Expenditures to Reach $1.3 Trillion," a press release (9/15/98).
5. Ibid.
6. Elyse Tanouye, *Wall Street Journal*.
7. "New Drugs boost pharmacy sales," *New York Times* (August 30, 1998).
8. Elyse Tanouye, *Wall Street Journal*.
9. Robert Langreth, "Earnings growth at drug companies could slow over next four years," *Wall Street Journal* (1/18/99).

Did you know?

Observation Stays Are a Significant Portion of Hospital Care

The Division of Health Care Finance and Policy has collected observation data from approximately 83 acute hospitals since the quarter beginning July 1, 1997. The first full year for reporting observation data is 1998. While the types of observation services provided may differ by hospital and payer, observation services may generally be defined as "services furnished on a hospital's premises which are necessary to evaluate a patient's condition, determine the need for possible admission to the hospital, and provide treatment. These services include the use of a bed and periodic monitoring by a hospital's physician, nursing and other staff."

	1998 Observation Stays	1998 Inpatient Stays
Total Number	150,000	775,054
Total Charges	$500 Million	$8.3 Billion
Median Charge	$2,400	$5,982
Average Length of Stay	21 hours	5.1 days
Top Payer	HMOs	Medicare
Top Three Conditions	cardiac	maternity
	maternity related	cardiac
	respiratory	respiratory

Source: Massachusetts Division of Health Care Finance and Policy Fiscal Year 1998 Hospital Case Mix and Charge Database and Observation Stay Database

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